

**IN THE UNITED STATES DISTRICT COURT FOR THE
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

JOE MITCHELL DORSEY,)	
)	
Plaintiff,)	
)	
v.)	CIVIL ACTION NO. 2:05-CV-1239-F
)	
MUNICIPAL COURT ANDALUSIA, et al.,)	
)	
Defendants.)	

AFFIDAVIT OF ANNETTE CAIN, L.P.N.

Before me, the undersigned notary public, in and for said County and State, personally appeared **Annette Cain, L.P.N.**, who, after first being duly sworn by me, deposes and states as follows:

1. My name is Annette Cain, L.P.N.. I am over the age of 19 years and have personal knowledge of the facts contained herein.

2. I am a licensed practical nurse. I obtained my L.P.N. degree in 1982 from McArthur State College in Opp, Alabama, and became licensed by the State of Alabama as an L.P.N. in 1982. From 1982 to 1985, I worked as an L.P.N. on the emergency room and surgery departments of Columbia General Hospital in Andalusia, Alabama. From 1985 to 1986, I worked as an L.P.N. for Dr. Joseph Herrod in Enterprise, Alabama, where my nursing care focused on behavioral malfunction. From 1986 to 1988, I was an L.P.N. at Opp nursing facility. From 1988 to 1990, I was an L.P.N. for Dr. Steven Price in Opp, Alabama, who had a private surgery practice. From 1990 to 1992, I was an L.P.N. at Oxford Home Health Care in Oxford, Alabama. From 1992 to 2005, I was an L.P.N. at Andalusia Manor Nursing Home.

3. From September 2005 to the present, I have been employed as an L.P.N. for Southern Health Partners, Inc. ("SHP") at the Covington County Jail in Andalusia, Alabama. In late

November 2005, I became medical team administrator.

4. SHP provides medical care to inmates in various jail facilities including the Covington County Jail. During the entire time of plaintiff's incarceration in the Covington County Jail, health care services have been provided to the inmates by SHP pursuant to a contract between SHP and the Covington County Commission. Health care in the jail is provided under the direction of a medical team administrator as well as a medical director. During the period complained of by the plaintiff in this action, the medical director in the jail was Dr. Millard McWhorter and I was the medical team administrator.

5. When an inmate in the jail requires routine medical care, he or she obtains an inmate sick call slip from the corrections officer on duty in the housing unit and that form is provided to the medical staff for action. Routine sick calls are conducted by the medical staff inside the housing unit.

6. As I understand the plaintiff's complaint in this case, the plaintiff alleges that I denied him medical attention upon his return to the jail from Andalusia Regional Hospital ("ARH") after being treated at ARH for complaints of pain arising out of a fall down some stairs.

7. I have reviewed SHP's medical chart concerning the plaintiff, a true and correct of which is attached hereto as Exhibit A.

8. On December 6, 2005, the plaintiff was booked into the Covington County Jail. On December 8, 2005, the plaintiff completed a medical screening form, wherein he mentioned a history of heart condition, mental health problems, ulcers and daily drug use.

9. On December 24, 2005, I received a telephone call from one of the correction officers at the jail, who reported that the plaintiff had fallen down some stairs. According to the officer, the plaintiff had been able to get up with assistance but had complained of great pain all over. The plaintiff had been transferred to the emergency room of ARH, and had returned to the jail with a

prescription for Motrin. Upon return to the jail, the plaintiff complained of general back pains, but had refused to get up for pill call.

10. Because I received this telephone call on Christmas Eve while I was not on shift, I wrote a late entry progress note on December 26, 2005, which documented my telephone call with the correction officer.

11. On December 25, 2005, Dr. McWhorter ordered that the plaintiff receive 800 mgs. of ibuprofen twice a day for seven days for his complaints of back pain.

12. On January 4, 2006, Dr. McWhorter saw the plaintiff in follow-up to his trip to ARH. The plaintiff complained that he had injured his lower back falling down stairs. Dr. McWhorter assessed the plaintiff as having a back contusion and ordered that he continue taking the medication (ibuprofen) he was currently taking for back pain.

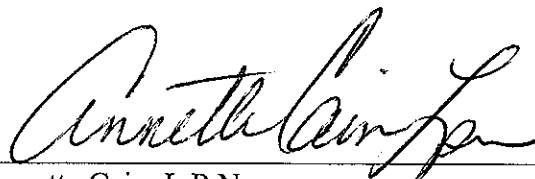
13. The plaintiff never completed a sick call slip for any problems related to any injury suffered from his fall down the stairs. In fact, the plaintiff has not completed any sick call slips requesting any medical attention or treatment since being booked into the jail.

14. Upon review of the plaintiff's medication administration record, he refused to take his morning dosage of ibuprofen on December 25, December 26, December 29, December 30, January 2 and January 3, 2005. He also refused to take his evening dose of ibuprofen on December 27, 2005.

15. All of the information contained herein is based upon my personal knowledge and the plaintiff's medical chart.

16. All necessary care provided to the plaintiff was appropriate, timely and within the standard of care.

17. On no occasion was the plaintiff ever at risk of serious harm, nor was I ever indifferent to any complaint that he made.

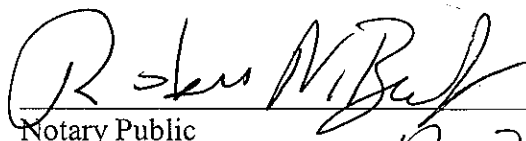


Annette Cain, L.P.N.

STATE OF ALABAMA)
COUNTY OF Madison)

I, the undersigned Notary Public in and for said county in said state, hereby certify that Annette Cain, whose name is signed to the foregoing and who is known to me, acknowledged before me that, being fully informed of the contents of said instrument, she executed the same voluntarily on the day the same bears date.

GIVEN UNDER MY HAND and official seal on this the 2 day of March, 2006.



Notary Public

My Commission Expires:

12-3-2007

Exhibit A

JAN-19-2006 03:55P FROM: COVIN JN CNTY JAIL

J: 14235535645

P.23

MEDICAL STAFF RECEIVING SCREENING FORM

Southern Health Partners, Inc.

LAST NAME: DORSEY FIRST NAME: Joe MIDDLE: Michael INTAKE DATE: 5-11-05 SCREENING DATE: 5-12-05 TIME: AM/PM

PRISON: Prison 3 mos. ago SEX: M SOCIAL SECURITY NO: 421-13-7354 I.D.#: 11-29-82

RECENT INMATE TRANSFER: N/A CURRENTLY UNDER PHYSICIAN'S CARE FOR CHRONIC CONDITION: N/A

USUAL / MEDICAL OBSERVATION: (Explain all "Yes" Answers) Circle Y or N:

Is inmate unconscious or showing visible signs of illness, injury, bleeding, pain, or other symptoms suggesting the need for immediate emergency medical referral?

yes

from

YES

NO

Are there any visible signs of fever, jaundice, skin lesions, rash, or infection, cuts, bruises, or minor injuries, needle marks, body vermin?

yes

scratches from rats

Y

N

Does the inmate exhibit any signs that suggest the risk of suicide, assault, or abnormal behavior?

yes

Y

N

Does the inmate appear to be under the influence of, or withdrawing from drugs or alcohol?

yes

Y

N

Is the inmate's mobility restricted in any way due to deformity, cast, injury, etc?

yes

Y

N

ASK THE INMATE THESE QUESTIONS: (Explain all "Yes" answers)

Have you had or been treated for (circle as appropriate) asthma, diabetes, epilepsy, heart condition, high blood pressure, mental health problems, seizures, ulcers, or other conditions?

yes

cannot remember name (did endoscopy)

Y

N

Have you taken or are you taking any medication(s) prescribed for you by a physician?

yes

Zurac 100mg qd for ulcers

Y

N

Are you allergic to any medications, foods, plants, etc?

yes

NKA

Y

N

Have you fainted or had a head injury within the last 72 hours?

yes

Y

N

Do you have or have you been exposed to AIDS, hepatitis, TB, VD, or other communicable disease?

yes

Y

N

Have you been hospitalized by a physician or psychiatrist within the last year?

yes

Y

N

Have you ever considered or attempted suicide?

yes

Y

N

Do you have a painful dental condition?

yes

Y

N

Are you on a specific diet prescribed by a physician?

yes

Y

N

Do you use drugs? How often?

yes

NO

Last time?

What kind?

Do you use alcohol? How often?

yes

NO

How much?

What kind?

How often?

Last time?

Are you pregnant, recently delivered or aborted, on birth control pills, having abdominal pain or discharge?

yes

Y

N

VITAL SIGNS

Pulse: 20 Temp: 68 Temperature: 97.6 Blood Pressure: 112/58

ALL CONCERNS FROM OFFICER INTAKE FORM BEEN ADDRESSED WITH INMATE?

yes

Y

N

ALL STATED CHRONIC CONDITIONS NOTED?

yes

Y

N

ARM LOCATION: R OR L IS H&P SCHEDULED FOR 14 DAY

MARKS:

I have been told and shown how to obtain medical services and advised in how to use the health services. I have been provided with information regarding the health services.

Signature: Joe Dorsey
 Signature: Constance Spivey

5-12-05
 5-12-05

JAN-19-2006 03:55P FROM:COUJ

JN CNTY JAIL

T0:14235535645

P.24

Covington County Sheriff

Printed: Wed May 11, 2005

MEDICAL SCREENING FORM**JOE MITCHELL DORSEY (S421137359)**

Booking Number

200007803

Booking Date

MAY 11th. 2005**ADMISSION OBSERVATIONS**

Is inmate conscious?	<input checked="" type="radio"/> Y <input type="radio"/> N	Is inmate capable of responding?	<input checked="" type="radio"/> Y <input type="radio"/> N	Can inmate walk on own?	<input checked="" type="radio"/> Y <input type="radio"/> N
Any difficulty breathing?	<input type="radio"/> Y <input checked="" type="radio"/> N	Is inmate hostile/aggressive?	<input type="radio"/> Y <input checked="" type="radio"/> N	Any visible signs of trauma, bleeding, wounds or illness?	<input checked="" type="radio"/> Y <input type="radio"/> N
Did arrest result in injury?	<input type="radio"/> Y <input checked="" type="radio"/> N	Any fever, swollen lymph nodes, or jaundice?	<input type="radio"/> Y <input checked="" type="radio"/> N	Is skin in good condition and free of vermin?	<input checked="" type="radio"/> Y <input type="radio"/> N
Is inmate under obvious influence of alcohol?	<input type="radio"/> Y <input checked="" type="radio"/> N	Is inmate under obvious influence of drugs?	<input type="radio"/> Y <input checked="" type="radio"/> N	Any visible signs of alcohol or drug withdrawal symptoms?	<input type="radio"/> Y <input checked="" type="radio"/> N
Does inmate suggest risk of suicide?	<input type="radio"/> Y <input checked="" type="radio"/> N	Do you consider inmate an escape risk?	<input type="radio"/> Y <input checked="" type="radio"/> N		

Observations

INMATE QUESTIONNAIRE**HAVE YOU EVER HAD/HAVE ANY OF THE FOLLOWING ILLNESSES OR CONDITIONS?**

Hepatitis	<input type="radio"/> Y <input checked="" type="radio"/> N	Heart Disease	<input type="radio"/> Y <input checked="" type="radio"/> N	Mental/Emotional Upset	<input type="radio"/> Y <input checked="" type="radio"/> N
Tuberculosis	<input type="radio"/> Y <input checked="" type="radio"/> N	Hypertension	<input type="radio"/> Y <input checked="" type="radio"/> N	Attempted Suicide	<input type="radio"/> Y <input checked="" type="radio"/> N
Sexually Transmitted Disease	<input type="radio"/> Y <input checked="" type="radio"/> N	Epilepsy/Convulsions	<input type="radio"/> Y <input checked="" type="radio"/> N	Asthma/Emphysema	<input type="radio"/> Y <input checked="" type="radio"/> N
Ulcers	<input checked="" type="radio"/> Y <input type="radio"/> N	Hemophiliac (bleeder)	<input type="radio"/> Y <input checked="" type="radio"/> N	Cancer	<input type="radio"/> Y <input checked="" type="radio"/> N
Kidney Trouble	<input type="radio"/> Y <input checked="" type="radio"/> N	Aids/Exposed to Aids	<input type="radio"/> Y <input checked="" type="radio"/> N	Diabetes	<input type="radio"/> Y <input checked="" type="radio"/> N
DT's	<input type="radio"/> Y <input checked="" type="radio"/> N	Skin Problems	<input type="radio"/> Y <input checked="" type="radio"/> N	Use Insulin	<input type="radio"/> Y <input checked="" type="radio"/> N
Drug Addiction	<input type="radio"/> Y <input checked="" type="radio"/> N	Alcoholism	<input type="radio"/> Y <input checked="" type="radio"/> N	Mental Illness	<input type="radio"/> Y <input checked="" type="radio"/> N
Recent Head Injury	<input type="radio"/> Y <input checked="" type="radio"/> N	Coughed/Passed Blood	<input type="radio"/> Y <input checked="" type="radio"/> N	Recent Hospital Patient	<input type="radio"/> Y <input checked="" type="radio"/> N
Recent Treatment	<input type="radio"/> Y <input checked="" type="radio"/> N	Use Needles	<input type="radio"/> Y <input checked="" type="radio"/> N	False Limbs/Teeth	<input type="radio"/> Y <input checked="" type="radio"/> N
Contagious Disease	<input type="radio"/> Y <input checked="" type="radio"/> N	Pregnant/Recent Delivery	<input type="radio"/> Y <input checked="" type="radio"/> N		

Doctors Name and Address

BONG ANDALUSIA

Health Insurance

NO

Special Diet

NO

Prescriptions/Medications

NO

Drug Allergies

NO

Descriptions

I have read the above carefully and have answered all questions correctly to the best of my knowledge.

Inmate's Signature

Joe Dorsey

Date:

Time:

Officers's Signature

C5006 Bill Blue
CJ006 BLUE, BILL

Date:

5-11-05

Time:

2210

MEDICATION ADMINISTRATION

RECORD

Released

MEDICATIONS		HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Nortec 150mg. iPO BID	AM	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
	PM	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
		1	2	3	4																												

CHARTING FOR 5-1-05		THROUGH 5-31-05	
Physician M. W. H. H. H. H. H.		Telephone No.	Medical Record No.
Alt. Physician		All Telephone	
Allergies NKA		Rehabilitative Potential	
Diagnosis			
Medicaid Number	Medicare Number 421-13-73-59	Approved By Doctor	
		By D.O.B.	Title
RESIDENT DORSEY, Joe Mitchell	11-29-82	Sex F	Date
		Room A	Admission Date
		Patient Code	

JAN-19-2006 03:54P FROM: COVINGTON CNTY JAIL

ID: 14235535645

P.21

SOUTHERN HEALTH PARTNERS, INC. SCREENING FORM

Southern Health Partners, Inc.

LAST NAME: Dorsey FIRST NAME: Joe MIDDLE: M SEX: M DATE OF BIRTH: 11-29-82

OFFICE: 18 SCREENING DATE: 2/18/05 SOCIAL SECURITY NO: 421-13-7359

CURRENTLY UNDER PHYSICIAN CARE FOR CHRONIC CONDITION: No

USUAL / MEDICAL OBSERVATION: (Explain all "Yes" Answers) Circle Y or N.

Question	YES	NO
Is inmate unconscious or showing visible signs of illness, injury, bleeding, pain, or other symptoms suggesting the need for immediate emergency medical referral?	Y	(N)
Are there any visible signs of fever, jaundice, skin lesions, rash, or infection: cuts, bruises, or minor injuries needle marks, bites, vermin?	Y	(N)
Does the inmate exhibit any signs that suggest the risk of suicide, assault, or abnormal behavior?	Y	(N)
Does the inmate appear to be under the influence of, or withdrawing from drugs or alcohol?	Y	(N)
Is the inmate's mobility restricted in any way due to deformity, cast, injury, etc?	Y	(N)

ASK THE INMATE THESE QUESTIONS: (Explain all "Yes" answers)

Question	YES	NO
Have you had or been treated for (circle as appropriate) asthma, diabetes, epilepsy, heart condition, high blood pressure, mental health problems, seizures, ulcers, or other conditions?	Y	(N)
Have you taken or are you taking any medication(s) prescribed for you by a physician?	Y	(N)
Are you allergic to any medications, foods, plants, etc.?	Y	(N)
Have you fainted or had a head injury within the last 72 hours?	Y	(N)
Do you have or have you been exposed to AIDS, hepatitis, TB, VD, or other communicable disease?	Y	(N)
Have you been hospitalized by a physician or psychiatrist within the last year?	Y	(N)
Have you ever considered or attempted suicide?	Y	(N)
Do you have a painful dental condition?	Y	(N)
Are you on any medicine not prescribed by a physician?	Y	(N)
Do you use drugs? How often?	Y	(N)
What kind?		
Last time?		
How much?		
Do you use alcohol? How often?	Y	(N)
What kind?		
Last time?		
How much?		
Are you pregnant, recently delivered or aborted, on birth control pills, having abdominal pain or discharge?	Y	(N)

NOTE VITAL SIGNS:

Respiration: 18 Pulse: 64 Temperature: 97.6 Blood Pressure: 120/78

HAVE ALL CONCERNS FROM OFFICER INTAKE FORM BEEN ADDRESSED WITH INMATE? YesWERE ALL STATED CHRONIC CONDITIONS NOTED? YesHBP IMPLANTED? Y OR N ARM LOCATION: R OR L IS H&P SCHEDULED FOR 14 DAYS Yes

REMARKS:

I have answered all questions truthfully. I have been told and shown how to obtain medical services and advised on how to obtain medication upon release. I give my consent for professional services to be provided to me by and through Southern Health Partners, Inc.

Signature: Joe Dorsey Date: 2/18/05

JAN-19-2006 03:55P FROM: COVIN... ON CNTY JAIL

ID: 14235535645

P.22

Covington County Sheriff

Printed: Tue Jul 19, 2006

MEDICAL SCREENING FORM**JOE MITCHELL DORSEY (S421137359)**

Booking Number

200008360

Booking Date

JULY 18th, 2006**ADMISSION OBSERVATIONS**

Is inmate conscious?	<input checked="" type="radio"/> Y <input type="radio"/> N	Is inmate capable of responding?	<input checked="" type="radio"/> Y <input type="radio"/> N	Can inmate walk on own?	<input checked="" type="radio"/> Y <input type="radio"/> N
Any difficulty breathing?	<input checked="" type="radio"/> Y <input type="radio"/> N	Is inmate hostile/aggressive?	<input type="radio"/> Y <input checked="" type="radio"/> N	Any visible signs of trauma, bleeding, wounds or illness?	<input type="radio"/> Y <input checked="" type="radio"/> N
Did arrest result in injury?	<input type="radio"/> Y <input checked="" type="radio"/> N	Any fever, swollen lymph nodes, or jaundice?	<input type="radio"/> Y <input checked="" type="radio"/> N	Is skin in good condition and free of vermin?	<input type="radio"/> Y <input checked="" type="radio"/> N
Is inmate under obvious influence of alcohol?	<input type="radio"/> Y <input checked="" type="radio"/> N	Is inmate under obvious influence of drugs?	<input type="radio"/> Y <input checked="" type="radio"/> N	Any visible signs of alcohol or drug withdrawal symptoms?	<input type="radio"/> Y <input checked="" type="radio"/> N
Does inmate suggest risk of suicide?	<input type="radio"/> Y <input checked="" type="radio"/> N	Do you consider inmate an escape risk?	<input type="radio"/> Y <input checked="" type="radio"/> N		

Observations

INFLAMMATION OF LUNGS**INMATE QUESTIONNAIRE****HAVE YOU EVER HAD/HAVE ANY OF THE FOLLOWING ILLNESSES OR CONDITIONS?**

Hepatitis	<input type="radio"/> Y <input checked="" type="radio"/> N	Heart Disease	<input type="radio"/> Y <input checked="" type="radio"/> N	Mental/Emotional Upset	<input type="radio"/> Y <input checked="" type="radio"/> N
Tuberculosis	<input type="radio"/> Y <input checked="" type="radio"/> N	Hypertension	<input type="radio"/> Y <input checked="" type="radio"/> N	Attempted Suicide	<input type="radio"/> Y <input checked="" type="radio"/> N
Sexually Transmitted Disease	<input type="radio"/> Y <input checked="" type="radio"/> N	Epilepsy/Convulsions	<input type="radio"/> Y <input checked="" type="radio"/> N	Asthma/Emphysema	<input type="radio"/> Y <input checked="" type="radio"/> N
Ulcers	<input type="radio"/> Y <input checked="" type="radio"/> N	Hemophiliac (bloeder)	<input type="radio"/> Y <input checked="" type="radio"/> N	Cancer	<input type="radio"/> Y <input checked="" type="radio"/> N
Kidney Trouble	<input type="radio"/> Y <input checked="" type="radio"/> N	Aids/Exposed to Aids	<input type="radio"/> Y <input checked="" type="radio"/> N	Diabetes	<input type="radio"/> Y <input checked="" type="radio"/> N
DT's	<input type="radio"/> Y <input checked="" type="radio"/> N	Skin Problems	<input type="radio"/> Y <input checked="" type="radio"/> N	Use Insulin	<input type="radio"/> Y <input checked="" type="radio"/> N
Drug Addiction	<input type="radio"/> Y <input checked="" type="radio"/> N	Alcoholism	<input type="radio"/> Y <input checked="" type="radio"/> N	Mental Illness	<input type="radio"/> Y <input checked="" type="radio"/> N
Recent Head Injury	<input type="radio"/> Y <input checked="" type="radio"/> N	Coughed/Passed Blood	<input type="radio"/> Y <input checked="" type="radio"/> N	Recent Hospital Patient	<input type="radio"/> Y <input checked="" type="radio"/> N
Recent Treatment	<input type="radio"/> Y <input checked="" type="radio"/> N	Use Needles	<input type="radio"/> Y <input checked="" type="radio"/> N	False Limbs/Teeth	<input type="radio"/> Y <input checked="" type="radio"/> N
Contagious Disease	<input type="radio"/> Y <input checked="" type="radio"/> N	Pregnant/Recent Delivery	<input type="radio"/> Y <input checked="" type="radio"/> N		

Doctors Name and Address

Health Insurance

Special Diet

Prescriptions/Medications

Drug Allergies

Descriptions

I have read the above carefully and have answered all questions correctly to the best of my knowledge.

Inmate's Signature _____ Date: _____ Time: _____

Officers's Signature **CJ021 BURKETTE, RODNEY** Date: _____ Time: _____



TB SKIN TEST VERIFICATION FORM

N/A

Prior to administering the TB skin test, please complete the information below. After administering the TB skin test, place this form in a central location for the test to be read within 72 hours. Once all information has been completed, file this completed form in the patient's medical record.

Inmate Name: Joe Daisey Cell # _____
SS# 421-13-7359 DOB 11-29-82 Male or Female

Date of TB Skin test: 7/19/05 Done by Nurse: [Signature]
Previous Positive: YES or NO Previous Therapy: YES or NO

TEST TO BE READ WITHIN 72 HOURS - COMPLETE BELOW INFORMATION:

Date TB Skin test was read: 7/21/05 Done by Nurse: [Signature]
Number mm: 0 Referral for Chest X-ray: YES or NO If yes, Date of CXR. _____

Comments: _____

JAN-19-2006 03:53P FROM: COVINGTON CNTY JAIL

TO: 14235535645

P. 18

Southern Health Partners, Inc.
TB Consent Form

Exp. Date:

Results:

Tuberculosis Screening and Treatment

What is Tuberculosis:

Tuberculosis ("TB") is a serious, infectious (transmitted through the air) disease that most commonly affects the lungs. In the lungs, the bacteria destroys elastic lung tissues and is replaced with fibrous connective tissues. The general symptoms of active TB are often subtle, unnoticeable and may include: Fatigue; Weight Loss; Fever; Chills; and Night Sweats. Symptoms of TB in the lungs may include: a persistent cough; chest pain; and coughing up blood. Although TB is preventable and can be cured with proper medication, 5% to 10% of those with active TB will die from the disease. This is usually due to patients not taking their medications correctly or improper drug treatment. TB is usually diagnosed through the use of the Mantoux tuberculin skin test. In this test, a dose of purified protein derivative from the Tubercle bacilli, which is non-infectious, is injected into the upper layer of skin on the inside of the forearm. Forty-eight to 72 hours after the injection, the test site is examined. In most cases a hardened area of tissue 10 millimeters or larger is considered an indication of infection with TB, but it is not necessarily an indication of having active TB. Chest x-rays and sputum smears and cultures are used to test for active TB.

There are several high risk groups in the US that are known to have a high rate of TB. They include:

- The homeless;
- IV drug users
- Alcoholics;
- Prison inmates
- The elderly;
- Persons with HIV infections/AIDS

Screening:

Upon consent, all new inmates who are processed into jail, without written proof of receiving TB testing in the past year, will receive purified protein derivative (PPD) during the health screening. A nurse will read the PPD forty-eight (48) to seventy-two (72) hours afterwards and document the results in the patient's medical file. The patient will be instructed during the health screening to the necessity of follow-up medical care, the results (both positive or negative) and treatment which may be necessary.

Treatment:

During the screening, if a patient states he/she is past positive, we will not plant PPD, but will obtain a chest x-ray to see if the tuberculosis is active. When a nurse reads a positive PPD, a chest x-ray will be ordered as per physician protocol. The patient will receive information regarding the test results, symptoms of TB, proposed treatment, and follow-up care, etc.

Should the chest x-ray suggest active TB, the local Health Department, SHP Medical Team Administrator, and SHP corporate office should be notified immediately. Initiating therapy/treatment should begin under the recommendations of the local Health Department and in conjunction with the jail physician. The jail will immediately segregate the patient from general population. All people who have come in contact with the patient will have a skin test. The patient will have restricted movement and visitors in the jail, and will be required to wear a mask at all times during contact with staff and/or other persons, until subsequent tests prove no longer infectious.

All new inmates who are processed into the jail, who are on treatment and deemed not infectious will be housed in general population. If a patient is released from Jail during therapy, the local Health Department will be notified and provided with the patient's release location and/or the patient's last known address.

Consent for Testing/Treatment:

I hereby give my consent for TB testing and/or treatment, if needed. I have read and understand the above information regarding testing and treatment procedures.

Signature: _____

Date: 7-19-05

Witness: _____

Date: 7/19/05

Confidential Medical Information

Covington County Sheriff Printed: Wed Dec 07, 2005	<h2 style="margin: 0;">MEDICAL SCREENING FORM</h2> <h3 style="margin: 0;">JOE MITCHELL DORSEY (S421137359)</h3>	Booking Number 200009374 Booking Date DECEMBER 6th, 2005
ADMISSION OBSERVATIONS		
Is inmate conscious? <input checked="" type="radio"/> Y <input type="radio"/> N	Is inmate capable of responding? <input checked="" type="radio"/> Y <input type="radio"/> N	Can inmate walk on own? <input checked="" type="radio"/> Y <input type="radio"/> N
Any difficulty breathing? <input type="radio"/> Y <input checked="" type="radio"/> N	Is inmate hostile/aggressive? <input type="radio"/> Y <input checked="" type="radio"/> N	Any visible signs of trauma, bleeding, wounds or illness? <input type="radio"/> Y <input checked="" type="radio"/> N
Did arrest result in injury? <input type="radio"/> Y <input checked="" type="radio"/> N	Any fever, swollen lymph nodes, or jaundice? <input type="radio"/> Y <input checked="" type="radio"/> N	Is skin in good condition and free of vermin? <input type="radio"/> Y <input checked="" type="radio"/> N
Is inmate under obvious influence of alcohol? <input type="radio"/> Y <input checked="" type="radio"/> N	Is inmate under obvious influence of drugs? <input type="radio"/> Y <input checked="" type="radio"/> N	Any visible signs of alcohol or drug withdrawal symptoms? <input type="radio"/> Y <input checked="" type="radio"/> N
Does inmate suggest risk of suicide? <input type="radio"/> Y <input checked="" type="radio"/> N	Do you consider inmate an escape risk? <input type="radio"/> Y <input checked="" type="radio"/> N	
Observations <div style="text-align: center; font-weight: bold;">DEMANDED TO TALK TO SOMEONE IN CHARGE</div>		
INMATE QUESTIONNAIRE		
HAVE YOU EVER HAD/HAVE ANY OF THE FOLLOWING ILLNESSES OR CONDITIONS?		
Hepatitis <input type="radio"/> Y <input checked="" type="radio"/> N	Heart Disease <input type="radio"/> Y <input checked="" type="radio"/> N	Mental/Emotional Upset <input type="radio"/> Y <input checked="" type="radio"/> N
Tuberculosis <input type="radio"/> Y <input checked="" type="radio"/> N	Hypertension <input type="radio"/> Y <input checked="" type="radio"/> N	Attempted Suicide <input type="radio"/> Y <input checked="" type="radio"/> N
Sexually Transmitted Disease <input type="radio"/> Y <input checked="" type="radio"/> N	Epilepsy/Convulsions <input type="radio"/> Y <input checked="" type="radio"/> N	Asthma/Emphysema <input type="radio"/> Y <input checked="" type="radio"/> N
Ulcers <input type="radio"/> Y <input checked="" type="radio"/> N	Hemophiliac (bleeder) <input type="radio"/> Y <input checked="" type="radio"/> N	Cancer <input type="radio"/> Y <input checked="" type="radio"/> N
Kidney Trouble <input type="radio"/> Y <input checked="" type="radio"/> N	Aids/Exposed to Aids <input type="radio"/> Y <input checked="" type="radio"/> N	Diabetes <input type="radio"/> Y <input checked="" type="radio"/> N
DT's <input type="radio"/> Y <input checked="" type="radio"/> N	Skin Problems <input type="radio"/> Y <input checked="" type="radio"/> N	Use Insulin <input type="radio"/> Y <input checked="" type="radio"/> N
Drug Addiction <input type="radio"/> Y <input checked="" type="radio"/> N	Alcoholism <input type="radio"/> Y <input checked="" type="radio"/> N	Mental Illness <input type="radio"/> Y <input checked="" type="radio"/> N
Recent Head Injury <input type="radio"/> Y <input checked="" type="radio"/> N	Coughed/Passed Blood <input type="radio"/> Y <input checked="" type="radio"/> N	Recent Hospital Patient <input type="radio"/> Y <input checked="" type="radio"/> N
Recent Treatment <input type="radio"/> Y <input checked="" type="radio"/> N	Use Needles <input type="radio"/> Y <input checked="" type="radio"/> N	False Limbs/Teeth <input type="radio"/> Y <input checked="" type="radio"/> N
Contagious Disease <input type="radio"/> Y <input checked="" type="radio"/> N	Pregnant/Recent Delivery <input type="radio"/> Y <input checked="" type="radio"/> N	
Doctors Name and Address		
Health Insurance		
Special Diet		
Prescriptions/Medications		
Drug Allergies		
Descriptions <div style="text-align: center; font-weight: bold;">DON'T WANT TO TALK</div>		
I have read the above carefully and have answered all questions correctly to the best of my knowledge.		
Inmate's Signature _____		Date: _____ Time: _____
Officers's Signature CJ014 BUSH, JIMMIE		Date: _____ Time: _____

JAN-19-2006 03:54P FROM: COVINGTON CNTY JAIL

TO: 14235535645

P.19

MEDICAL STAFF RECE' NG SCREENING FORM

Southern Health Partners, Inc.

LAST NAME: DOLSEY FIRST NAME: JOE MIDDLE: M DATE OF BIRTH: 12/10/65 SCREENING DATE: 12/10/05 TIME: 1440
 PREVIOUS INCARCERATIONS: YES SOCIAL SECURITY NO: 421/37359 DOB: 11-29-82
 CURRENT INSURANCE COVERAGE: N/A CURRENTLY UNDER PHYSICIAN'S CARE FOR CHRONIC CONDITION: N/A

VISUAL / MEDICAL OBSERVATION: (Explain all "Yes" Answers) Circle Y or N:

	YES	NO
Is inmate unconscious or showing visible signs of illness, injury, bleeding, pain, or other symptoms suggesting the need for immediate emergency medical referral? If yes:	Y	<u>(N)</u>
Are there any visible signs of fever, jaundice, skin lesions, rash, or infection, cuts, bruises, or minor injuries, needle marks, body vermin? If yes:	Y	<u>(N)</u>
Does the inmate exhibit any signs that suggest the risk of suicide, assault, or abnormal behavior? If yes:	<u>(Y)</u>	N
Does the inmate appear to be under the influence of, or withdrawing from drugs or alcohol? If yes:	Y	<u>(N)</u>
Is the inmate's mobility restricted in any way due to deformity, cast, injury, etc. If yes:	Y	<u>(N)</u>

ASK THE INMATE THESE QUESTIONS: (Explain all "Yes" answers)

Have you had or been treated for: (circle as appropriate) asthma, diabetes, epilepsy, heart condition, high blood pressure, mental health problems, seizures, ulcers, or other conditions? Other: <u>inflammation of the gut</u>	<u>(Y)</u>	N
Have you taken or are you taking any medication(s) prescribed for you by a physician? If yes: <u>has taken Zyprexa & Zolof in past</u>	Y	<u>(N)</u>
Are you allergic to any medications, foods, plants, etc.? <u>Yes</u>	Y	<u>(N)</u>
Have you fainted or had a head injury within the last 72 hours? If yes: <u>but head not hurt</u>	<u>(Y)</u>	N
Do you have or have you been exposed to AIDS, hepatitis, TB, VD, or other communicable disease? If yes:	Y	<u>(N)</u>
Have you been hospitalized by a physician or psychiatrist within the last year? If yes: <u>12/10/05</u>	<u>(Y)</u>	N
Have you ever considered or attempted suicide? If yes:	Y	<u>(N)</u>
Do you have a painful dental condition? If yes:	Y	<u>(N)</u>
Are you on a specific diet prescribed by a physician? If yes:	Y	<u>(N)</u>
Do you use drugs? How often? <u>daily</u> What kind? <u>heroin</u>	Y	<u>(N)</u>
Do you use alcohol? How often? <u>9am</u> What kind? <u>beer</u>	<u>(Y)</u>	N
Females LMP Date: <u>N/A</u> Are you pregnant, recently delivered or aborted, on birth control pills, having abdominal pain or discharge? If yes:	Y	N

NOTE VITAL SIGNS:

Respiration: 24 Pulse: 78 Temperature: _____ Blood Pressure: 128/92

HAVE ALL CONCERNS FROM OFFICER INTAKE FORM BEEN ADDRESSED WITH INMATE? YesARE ALL STATED CHRONIC CONDITIONS NOTED: YesPPD IMPLANTED? Y OR (N) ARM LOCATION: R OR L IS H&P SCHEDULED FOR 14 DAYS: YesREMARKS: explained sick call care

I have answered all questions truthfully. I have been told and shown how to obtain medical services and advised on how to obtain medication upon release.
 I hereby give my consent for professional services to be provided to me by and through Southern Health Partners, Inc.

Inmate's Signature _____

Inmate's Signature and Title _____

Date _____

Date _____

Southern Health Partners
MASTER PROBLEM LIST

For Use with Chronic Condition Patients. Chronic Conditions are classified as (but not limited to): Diabetes (IDDM/NIDDM), Hypertension, Pregnancy, HIV/AIDS, Asthma, Seizures, Diagnosed Mental Illness, CHF, Hepatitis.

Patient's Name (Last/First/Middle): James J. O.
 ID#: 42137359 DOB: 11/29/50 Sex: M Intake Date/s: _____

Date Problem Identified/Dx	Chronic Condition	M.D. Comments	Date Of Initial M.D. Eval	M.D. Initials
12/9/55	Mental	Health		

H & P Date: 5/35 Allergies: None
 PPD Test Date: 7/19/55 PPD Results Date: 7/19/55 PPD Results: _____ mm

Facility Name: Winston A. G.

Physician's Orders

Southern District of Texas

Inmate Name: <u>Worsey, Joe M</u>	Facility: <u>Covington County Jail</u>
SS#: <u>42137359</u>	
DOB: <u>11-29-82</u>	
Allergies: <u>NKA</u>	

Date: <u>12-8-05</u> ① Celebra 20mg QD ② Thorazine 50mg BID ③ IBU 800mg BID x 7 days T.O. Dr. [Signature] M.D. Sig. [Signature]	Date: M.D. Sig.
Date: <u>12-25-05</u> ① IBU 800mg BID x 7 days per tx [Signature] M.D. Sig. [Signature]	Date: M.D. Sig.
Date: <u>1/10/06</u> D/C Celebra & Thorazine I/M Non-Compliant. 8 Hx for 5 yrs. before [Signature] M.D. Sig. [Signature]	Date: M.D. Sig.
Date: M.D. Sig.	Date: M.D. Sig.

Last Name Dorsey	First Name Joe	Attending Physician McWhorter	Room No	Hosp No
Notes Should Be Signed by Physician				

12/20/05 1115 Brought to jail from hsp. (swallowed bag of cocaine) (amb.)
 steady. Brown on face. Uncooperative to officers. Clothes
 removed & placed on suicide watch. Sets & head down -
 will not speak to nurse. Information brought to medical st.
 about hsp. stay. **Dorsey-Pas**

12/20/05 1900 Cycled to jail to evaluate inmate. Officer states he has been
 hitting his head on the wall. Inmate found in 4th. restraint
 chair. Able to move all extremities. Straps around wrists /
 ankles loose. Pairs present. Reddened area @ shoulder / upper
 arm from struggling. Calm @ present but severely depressed &
 suicidal. Has 16 on suicide - area on face where inmate
 inmate allegedly hit his head repeatedly. Area top of head reddens
 12/20/05. Superficial abrasion noted. Pedicure or vaccination noted
 (attempted to scratch self at 173 - to get inmate contained to
 success. Will report to nurse to ask about in cell. "He's was
 on celloff & Expressa previously but "got taking it" - trying to
 live & manipulate family, phone. & threat death of mother & son.
 "He's not such a child". Volunteering to nurse. mental danger
 physical pain of not being able to cope. "He's not really
 here for" - using cocaine to deal & pass. - Man. wants very constant
 for short intervals. Copying others. Inmate appears to want
 more than was told. In hospital. Glad it's over & he's
 back home & happy. From Mar. 1999 having fun. He's the
 "man" for the moment.

JAN-19-2006 03:51P FROM: COURT IN CNTY JAIL

J: 14235535645

P.12



Confidential Work Product

INPATIENT HOSPITALIZATION FAX FORM

THE FOLLOWING COMPLETED INFORMATION MUST BE FAXED TO THE CORPORATE OFFICE (423-553-5645) IMMEDIATELY FOLLOWING AN INMATE'S INPATIENT ADMISSION TO THE HOSPITAL. ANY UPDATED INFORMATION SHOULD BE COMPLETED AT A LATER DATE WITH THE ORIGINAL FORM BEING MAILED TO THE CORPORATE OFFICE.

INMATE INFORMATION:

Name: Joe Mitchell Dorsey Sex: M or F DOB: _____
 SS #: 421-B-7359 Classification: ☐ City Inmate ☒ County Inmate ☐ State Inmate

Potential 3rd party reimbursement/insurance and/or other bill responsibility information: _____
 (Please note if SHP is NOT the responsible payor of the bill)

Hospital Admit Date: 12/7/05 Hospital Name: Andalusia Regional Hospital
 Hospital Phone #: 334-222-8466 Treating/Admitting Physicians Name: _____

Was Admission: ☒ Emergency Admission ☐ Planned Admission for Treatment

Anticipated Length of Hospital Stay: _____

Specific Reason(s) for Admission: Emergency admission for injury
to the back of his head

Anticipated Treatment: Observation

Was SHP jail physician notified? Y or N

Was Captain and/or Jail Administrator notified? Y or N

Nurse's Signature: _____ Date: 1/1/06

Facility Name: _____ State: _____

Please re-fax the form with Patient's Discharge Date: 12/07/05
 upon release from the hospital. Thank you.

Confidential

PROGRESS NOTES

N/A

First Name Dorsey Joe	Attending Physician McWhorter	Room No. 14	Inmate No. 42113735
--------------------------	----------------------------------	----------------	------------------------

Date Notes Should Be Signed by Physician

12/8/05
 Call relating that inmate Go Chest pain + Lancing head on wall. Also inmate requesting to go to ER. CD will call back w/ blood pressure + HR of inmate approx. 20 mins. Later - CD called + relates that inmate was sleeping soundly + breathing w ease + will be kept in holding to monitor closely. Instructed CD to call if any changes in inmates condition to resp status or further w chest pain. ——— A. Ben for N/A

12/8/05
 1010 Inmate seen for medical screening. Relates that He quit going to MH + quit taking meds around 5 years ago. Expresses no suicidal tendencies or ideations. Spoke to Dr. McWhorter + new orders received. ——— A. Ben for N/A

PROGRESS NOTES

Last Name: Waller First Name: Joe Attending Physician: McWhorter Room No: A Hosp. No: 42113735

Date

Notes Should Be Signed by Physician

12/26/05 Late entry for 12/24/05 approx 8³⁰ PM.
 inmate observed by C.O.'s in jail falling
 from stairs onto concrete flooring. Inmate
 C.O.'s report that he was able to
 get up to assist but got great pain all
 over. They reported to prison area.
 Nurse was not called neither C.O.'s
 transferred to ER. Inmate returned
 to RV for Motion. C.O. General work
 runs but also not get for
 pill call. ——— C. C. for

1/4/06 S - injured lower back & head
 through stairs. E.g. right
 shoulder is not neurological
 problems

Back pain tenderness occ
 mid lower back
 none to head neurological
 problems or deficits
 A - Back Confusion
 P - continue needs
 JTW



**AUTHORIZATION FOR RELEASE OF MEDICAL
INFORMATION TO CORRECTIONAL FACILITY**

To AP?

I hereby authorize any hospital, clinic, physician's office, and/or health agency to provide any information they may have acquired while attending me for a medical, dental, or psychiatric problem to Southern Health Partners Inc. who is the medical care provider of this Correctional Facility. Such information may include the following items:

Summary of positive findings, most recent history, physical exam including any diagnostic tests
Medical/dental/psychiatric/psychological diagnosis and treatment regimen when I am hospitalized
Hospital discharge summary for any/all hospitalization(s), Laboratory and/or Special Study Reports
Any other medical/dental/psychiatric services I may have previously had, currently receiving, or
Future treatment plans, Other Records X Barry reports for 12/15

I understand my records are protected under state and/or federal privacy laws and cannot be disclosed to any other outside party without my written consent unless otherwise provided for by state or federal law. Records received will be kept within the patient's medical file within the correctional medical unit and be used for the provision of health care services.

I release responsibility and/or liability from the correctional facility for the release of the above requested medical information to the medical unit to the extent indicated and authorized.

Please send requested documents:

to the following address:

County Name:

Street Address:

City/State/Zip:

ATTN: MEDICAL UNIT/SOUTHERN HEALTH PARTNERS

Livingston County Jail

290 N. Tipton St. DE

Andalusia, AL Fax 334-478-2655

My name: Joe M. Nowicki

Birth Date: 11-24-82

My County Number: 421-13 7359

Date of Service(s): 12-23-05

My Signature: Joe M. Nowicki

Date: 12/28/05

Christie Wilson

Date: 12/28/05

I, the undersigned, being a duly qualified medical professional, do hereby certify that the above information is true and correct to the best of my knowledge and belief. I understand that the release of this information is for the use of the medical unit only and that it is not to be used for any other purpose. I further understand that the release of this information is subject to the terms and conditions of the authorization and that I am not to be held responsible for any misuse of the information. I understand that the release of this information is for the use of the medical unit only and that it is not to be used for any other purpose. I further understand that the release of this information is subject to the terms and conditions of the authorization and that I am not to be held responsible for any misuse of the information.

12/28/05
AP?



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO CORRECTIONAL FACILITY

To ARH

I hereby authorize any hospital, clinic, physician's office, and/or health agency to provide any information they may have acquired while attending me for a medical, dental, or psychiatric problem to Southern Health Partners, Inc. who is the medical care provider of this Correctional Facility. Such information may include the following items:

Summary of positive findings, most recent history, physical exam including any diagnostic tests
Medical/dental/psychiatric/psychological diagnosis and treatment regimen when last treated
Hospital discharge summary for any/all hospitalization(s); Laboratory and/or Special Study Reports
Any other medical/dental/psychiatric services I may have previously had, currently seeking, or future treatment plans. Other Records X-rays

I understand my records are protected under state and/or federal privacy laws and cannot be disclosed to any other outside party without my written consent unless otherwise provided for by state or federal law. Records received will be kept within the patient's medical file within the correctional medical unit and to be used for the ongoing provision of health care services.

I release responsibility and/or liability from the correctional facility for the release of the above requested medical information to the medical unit to the extent indicated and authorized.

Please send requested document to the following address:

County Name: Cal.
Street Address: 290 Hillcrest Dr
City/State/Zip: Andalusia, AL 36420

ATTN: MEDICAL UNIT/SOUTHERN HEALTH PARTNERS
FAX: 334-428-2855

Print Name: Joe DORSEY

Birth Date: 11/29/82

SSN: 421-13-7357

Dates of Service(s): 12/26/05

Signature: Joe Dorsey
W. Williams, Jr.

Date: 1/4/06

Date: 1/4/06

Faxed
1/4/06
DW

JAN-19-2006 03:51P FROM:COVIN JN CNTY JAIL

:14235535645

P.13

Age/Sex: 23 M

DORSEY, JOE M (ADM IN)

Page: 1

Unit #: D000046995

D. ICU-D.315-A

Account#: D00100971678

Smith, Joanne M

Admitted: 12/06/05 at 2230

Andalusia Reg Hosp Patient Care

DISCHARGE INSTRUCTIONS

Discharge Instructions

12/07/05 1529 JLL

<<DISCHARGE INSTRUCTIONS>>

Discharge to: Home

Discharge Date: 12/07/05 Discharge Time: 1530

Home Diet Instructions: N

Diet: AS TOLERATED

Fluid Restrictions: N ML Per Day:

Weight Monitoring: N

Frequency:

Wound Care: N

At Home Instructions for the care of you:

Activity: N

Recommendations:

<<Discharge Med Instructions>>

Medication Dose Route Time

: NONE

<<Special Instructions>> N

: REPORT TO THE EMERGENCY ROOMS IF HAVING ANY
DIFFICULTIES OR DISTRESS. *F/U c Dr. McWhorter for antidepressant therapy.*

<<Follow Up>> N MD:

Appointment made for:

Call For Appointment:

MD:

Appointment made for:

Call For Appointment:

<<Referrals>>

Patient Choice Letter: N

Agency Or Facility Name:

Special Instructions/Contact Name:

Home Health: Start Date:

Home Health Notified of Discharge:

Name of Person Notified:

Home Health Agency to Follow For:

<<Pain Mangement>> N

Pain on Discharge: Pain Score:

If Yes, Pain Management Techniques:

If you have any questions about your discharge instructions or needs call:

CALL DR. SMITH 222-0184 *Error*

Patient Family Member

Monogram Initials	Name	Nurse Type
JLL	DNURJLL LEWIS, JACLYN	RN

JAN-19-2006 03:52P FROM: COVIN IN CNTY JAIL

:14235535645

P.15

Exam Date: 1/13/06 S.S.#: 421-13-7354 ID# _____
 Inmate Name: Darsey Joe Mitchell Date Booked: 12/6/05
 Alias: 0 (Last) (First) (Middle) County: COV. CO
 Address: PO Box Falls St Apt 4 (Last) (First) (Middle) (City) (State) (Zip) 36428
 Telephone: 334-222-3307 Birthdate: 11/29/82 (City) (State) (Zip) Religion: Baptist
 Education Completed: 10th grade Special Education: 0
 Marital Status: S M W D Separated Read/Write English: YES NO Other: _____
 Previous Incarcerations: (Facility/Date) COV. CO. See P. 15

MEDICAL HISTORY

Notify in Emergency: Dr. Quinita Darsey Wife
 Address: Same as above (Name) (Street) (City) (State) (Zip) (Relationship)
 Health Insurance: 0 (Type of Insurance) (State) (Zip) Phone: _____
 Family Physician: 0 (Name) (Street Address) (City) (State) (Zip) (Policy Number)
 Past Hospitalizations (include surgeries): 0

Head Injury with Loss of Consciousness: YES (Location) (Street Address) (City) (State) (Zip) Last Tetanus: 2 days (City) (State) (Zip) Immunization: _____
 Allergies: 1/20A
 Current Medication(s): 0

MENTAL HEALTH EVALUATION

Hospitalization for Mental Health Reasons: YES NO If Yes, Why: _____
 Where: _____ (Location) (Street Address) (City) (State) (Zip) When: _____ (Date)
 Psychotropic Meds (Specify type and last dose) Therapine 3 days ago
 Prior Counseling/Out-Patient Treatment for: Mental Health
 Where: SEAMH Andalusia (Location) (Street Address) (City) (State) (Zip) When: _____ (Date)
 Have you ever attempted suicide: NO How: 0 (City) (State) (Zip) When: _____ (Date)
 Have you recently considered committing suicide? 0 When: _____ (Date)
 Do people consider you a violent person? 0
 Have you ever been arrested for a violent crime/sexual offense? (Specify) DV
 Street drugs: Cocaine 2x month Smoker (Type-Quantity) (How often) (How long) Smoker: YES Eton: NO
 Inmate's Signature: Joe Mitchell Date: 1/13/06
 Inmate's Signature: Joe Mitchell Date: 1/13/06
 Inmate's Signature: _____ Date: _____
 Inmate's Signature: _____ Date: _____
 Inmate's Signature: _____ Date: _____

JAN-19-2006 03:52P FROM: COVINGTON CNTY JAIL

TO: 14235535645

P.16

MEDICAL HISTORY & PHYSICAL ASSESSMENT

Problems	Yes	No	Problems	Yes	No	Problems	Yes	No
Vision		✓	Hypertension		✓	Gonorrhea		✓
Hearing		✓	Anemia		✓	Syphilis		✓
Balance/Dizziness		✓	Blood		✓	Muscle Problem		✓
Blackouts		✓	Stomach Pain		✓	Joint Problem		✓
DT's		✓	Heartburn		✓	Arthritis		✓
Headaches		✓	Ulcer		✓	Other		✓
Seizures		✓	Nausea/Vomiting		✓	Other		✓
Nervous Disorder		✓	Gall Bladder		✓	Regular Menstrual Period		✓
Throat		✓	Liver		✓	Irregular Menstrual Period		✓
Teeth		✓	Hepatitis		✓	# of days Menstrual Period		✓
Asthma		✓	Diabetes		✓	LMP		✓
Hay Fever		✓	Kidney Disease		✓	Gravida/Para		✓
Pneumonia		✓	Bladder Infection		✓	Last Pap		✓
Tuberculosis		✓	Trouble Voiding		✓	Contraception		✓
Heart		✓	Pediculi (lice)		✓	Other		✓

EXAM:

Age 23 Sex M Race B Ht. 6' Wt. 160.5
Pulse 88 BP 118/70 Temp. 97.2 Resp. 18

Area/Type	N	A/Comment	Area/Type	N	A/Comment
Skin: Color Condition Turgor Recent Inj		OK	Chest (Breasts): Configuration Auscultation Respirations Cough/Sputum		OK
Head: Glasses Pupils Sclera Conjunctiva Vision		OK	Heart: Auscultation Radial pulses Apical pulse Rhythm		OK
Ears: Appearance Canals Hearing		OK	Extremities: Pulsos Edema Joints		OK
Mouth: Teeth/Gums Dentures Plates Throat Tongue Fossils		OK	Abdomen: Shape Palpation Hernia Bowel Sounds		OK
Nose		OK	Spine		OK
Neck: Veins Mobility Thyroid Carotids Lymph nodes		OK	Genital/Urinary System		OK

LABORATORY TESTS

	Date & Initial	Results
Was PPD planted and read timely?	1/15/06 <u>OK</u>	1/17/06 <u>Res. Active</u>
VDRL, RPR	<u>0</u>	
Other Lab Tests needed	<u>0</u>	
Pregnancy Test?	<u>0</u>	

MENTAL HEALTH OBSERVATION

	N	A/Comment
Orientation (person, place, time)		OK 3
General appearance (motor behavior, mannerisms, Affect (mood))		OK/OK/OK
Content of thought, history of suicide, present thoughts of suicide		0

Physical Examiner's Signature: V. W. Williams, MDPhysician's Signature: AMMDate: 1/15/06Time: 11:15/06



TB SKIN TEST VERIFICATION FORM

Prior to administering the TB skin test, please complete the information below. After administering the TB skin test, place this form in a central location for the test to be read within 72 hours. Once all information has been completed, file this completed form in the patient's medical record.

Inmate Name Joe Mitchell Dickey Cell # A
SS# 421-P-7353 DOB 11/29/82 ☒ Male or Female

Date of TB Skin test 1/15/06 Done by Nurse [Signature]
Previous Positive: YES or ☒ NO Previous Therapy YES or NO

TEST TO BE READ WITHIN 72 HOURS - COMPLETE BELOW INFORMATION

Date TB Skin test was read 4/17/06 Done by Nurse [Signature]
Number mm: 0 Referral for Chest X-ray YES or ☒ NO If yes Date of Exp

Comments _____

Tuberculosis Screening and Treatment

What is Tuberculosis:

Tuberculosis ("TB") is a serious, infectious (transmitted through the air) disease that most commonly affects the lungs. In the lungs, the bacteria destroys elastic lung tissues and is replaced with fibrous connective tissues. The general symptoms of active TB are often subtle, unnoticeable and may include: Fatigue; Weight Loss; Fever; Chills; and Night Sweats. Symptoms of TB in the lungs may include: a persistent cough; chest pain; and coughing up blood. Although TB is preventable and can be cured with proper medication, 5% to 10% of those with active TB will die from the disease. This is usually due to patients not taking their medications correctly or improper drug treatment. TB is usually diagnosed through the use of the Mantoux tuberculin skin test. In this test, a dose of purified protein derivative from the Tubercle bacilli, which is non-infectious, is injected into the upper layer of skin on the inside of the forearm. Forty-eight to 72 hours after the injection, the test site is examined. In most cases a hardened area of tissue 10 millimeters or larger is considered an indication of infection with TB, but it is not necessarily an indication of having active TB. Chest x-rays and sputum smears and cultures are used to test for active TB.

There are several high risk groups in the US that are known to have a high rate of TB. They include:

- The homeless;
- IV drug users
- Alcoholics;
- Prison inmates
- The elderly;
- Persons with HIV infections/AIDS

Screening:

Upon consent, all new inmates who are processed into jail, without written proof of receiving TB testing in the past year, will receive purified protein derivative (PPD) during the health screening. A nurse will read the PPD forty-eight (48) to seventy-two (72) hours afterwards and document the results in the patient's medical file. The patient will be instructed during the health screening to the necessity of follow-up medical care, the results (both positive or negative) and treatment which may be necessary.

Treatment:

During the screening, if a patient states he/she is past positive, we will not plant PPD, but will obtain a chest x-ray to see if the tuberculosis is active. When a nurse reads a positive PPD, a chest x-ray will be ordered as per physician protocol. The patient will receive information regarding the test results, symptoms of TB, proposed treatment, and follow-up care, etc.

Should the chest x-ray suggest active TB, the local Health Department, SHP Medical Team Administrator, and SHP corporate office should be notified immediately. Initiating therapy/treatment should begin under the recommendations of the local Health Department and in conjunction with the jail physician. The jail will immediately segregate the patient from general population. All people who have come in contact with the patient will have a skin test. The patient will have restricted movement and visitors in the jail, and will be required to wear a mask at all times during contact with staff and/or other persons, until subsequent tests prove no longer infectious.

All new inmates who are processed into the jail, who are on treatment and deemed not infectious will be housed in general population. If a patient is released from Jail during therapy, the local Health Department will be notified and provided with the patient's release location and/or the patient's last known address.

Consent for Testing/Treatment:

I hereby give my consent for TB testing and/or treatment, if needed. I have read and understand the above information regarding testing and treatment procedures.

Signature: _____

Date: 1/13/06

Witness: Dr. Williams

Date: 1/13/06

Confidential Medical Information

JAN-19-2006 03:50P FROM:COVIL IN CNTY JAIL

J:14235535645

P.10

**Andalusia
Regional Hospital**649 South Three Notch Street
Andalusia, Alabama

DEA AC 9709897

For _____
 Address _____
 R _____
 DORSEY, JOE M
 D00100996315 D000046995
 M/23 11/29/82 421-13-7359
 HAMILTON, DUNSTON KIR

Date _____

YES NO
 LABEL ☐ ☒

Reg. No. _____

DISPENSE AS WRITTEN

PRODUCT SELECTION PERMITTED

REPT OF DICT 1 2 3 4 5 11 TIMES P.R.N. ☐ NON-REP. ☒

AI-255 (Rev 8/00)

MEDICATIONS		HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Celebra 20mg QD	A		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	P		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Morphine 50mg BID	A		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	P		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
IBU 800mg BID X 7 days	A		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	P		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
IBU 800mg BID X 10 days 5:00pm 4/5	A		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	P		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20											

Date _____
 Certification _____

421137359
J. C. Dorsey

MEDICATION ADMINISTRATION RECORD

COVINGTON COUNTY JAIL
 DORSEY, JOE
 REPORT DATE : 01/06

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
CITALOPRAM HBR 20 MG TABL	12/08/06																														
CELEXA 30 MG TABLET	AM																														
TAKE 1 TABLET ONCE DAILY																															
CHLORPROMAZINE 50 MG TABL	12/08/06																														
THORAZINE 50 MG TABLET	AM																														
TAKE 1 TABLET TWICE DAILY	PM																														
IBU 800mg T po																															
Bid x 10 days																															
Robaxin 750mg T po																															
Bid x 30 days																															
IBU 800mg T po																															
Bid x 30 days																															

STARTING FOR	01/01/06	THROUGH	01/31/06	PAGE	1 OF 1
Physician	MCWHORTER			Telephone No.	
Physician	MCWHORTER			Alt Telephone	
Physician	NKA			Medical Record No.	
				Notable/	
				Potential	

Medicaid Number	Medicare Number	Approved By Doctor	Date
		By	
Joe Dorsey			